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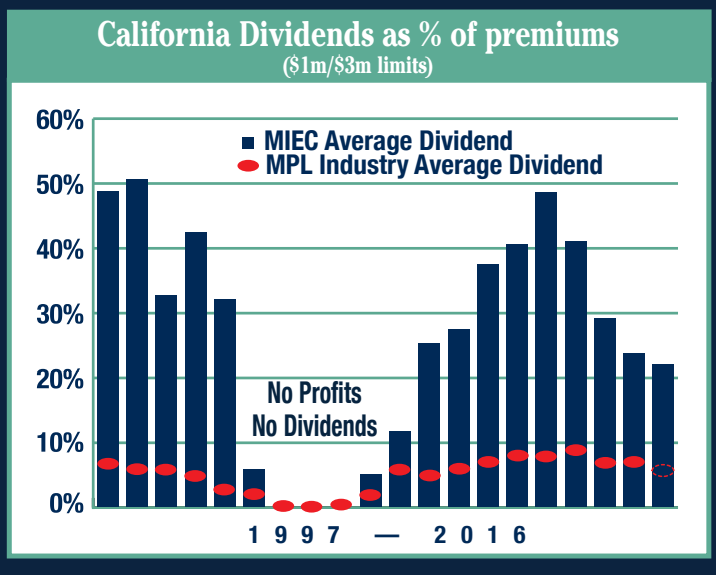

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The magazine of the Marin Medical Society

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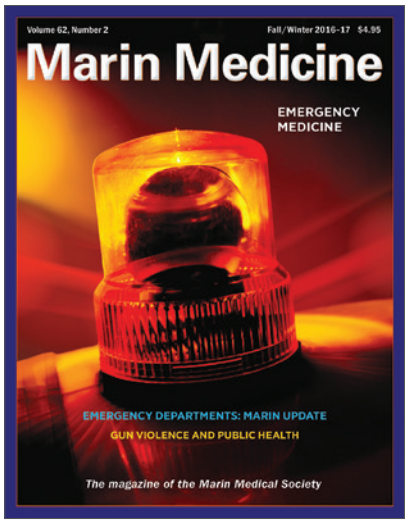

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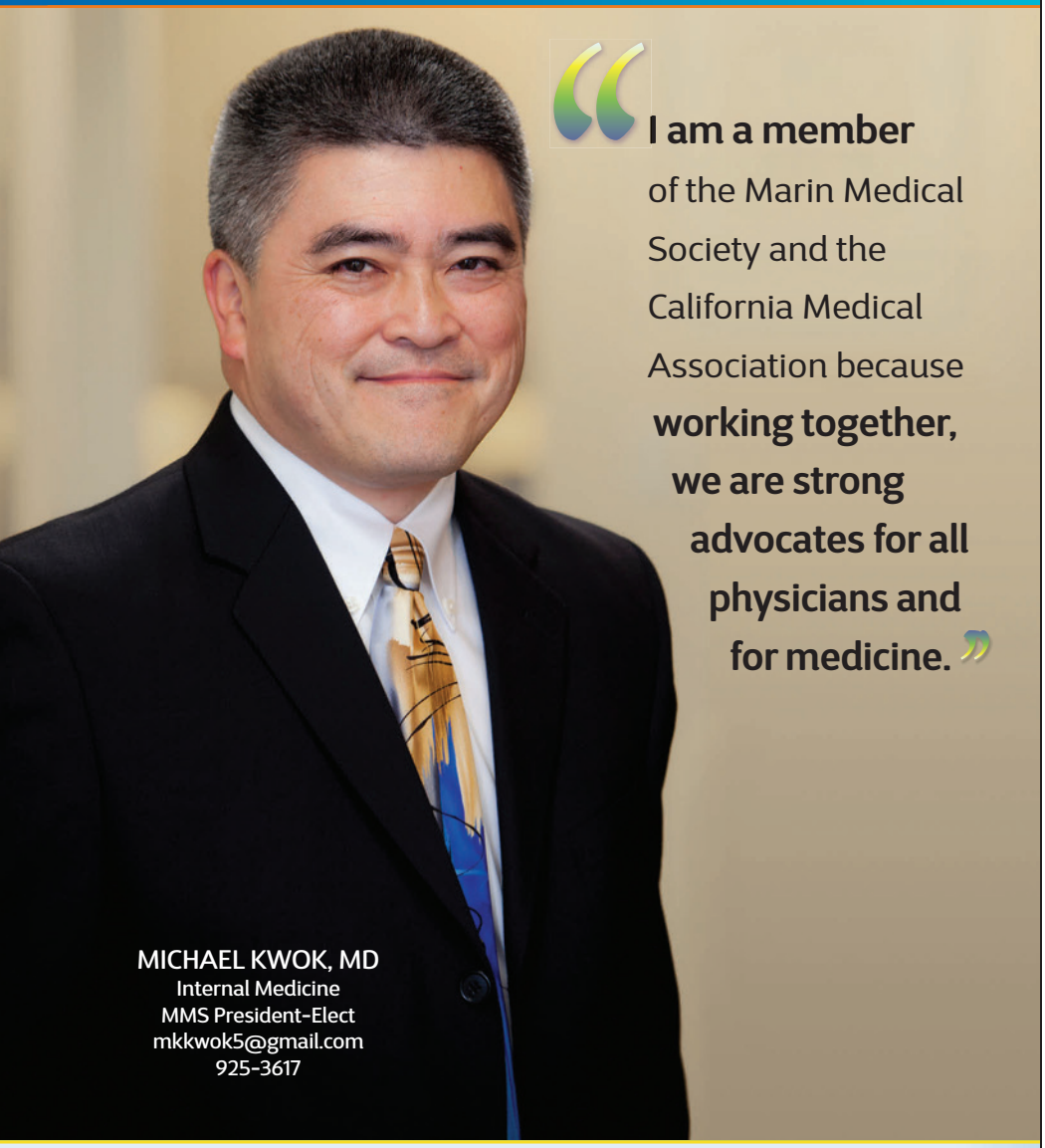
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Emergency: A View from Many Angles

Irina deFischer, MD

Scott and I recently saw the movie *Sully*, about airline Captain Chesley Sullenberger's successful landing of an Airbus A320 on the icy Hudson River in January 2009 after both engines were disabled when the plane ran into a flock of birds. Though the storyline focuses mainly on the NTSB investigation, I was fascinated by the response of the pilots and crew to the emergency, and how, with the help of ferry pilots, helicopters and other emergency personnel, they were able to save all 155 souls on board with only minor injuries. Though they had never been in that situation before, they were very familiar with the equipment and had clearly rehearsed the procedures enough so as to be able to perform them almost without thinking, remaining calm throughout the process.

This issue of *Marin Medicine* focuses on emergency care from several angles. Retired Marin General emergency physician Dr. Miles Riner reviews the pivotal role of Emergency Rooms in our health care system and warns that many ERs are underfunded and may be unprepared to deal with potential disasters and epidemics. Dr. Veronica Jordan suggests we try to imagine "What if Primary Care Were as Easy to Access as the ED?" Neurologist Dr. Jon Artz, medical director of stroke services at Kaiser San Rafael, describes the Northern California Stroke Express Program, which uses a team approach to evaluate and treat stroke patients as quickly as possible using local and regional resources simultaneously.

Dr. deFischer, a family physician at Kaiser Petaluma, is chair of the Marin Medicine *editorial board.*

In a three-article special section, "Emergency Care in Marin," Dr. Jim Dietz, chair of emergency medicine at Marin General, outlines the plans for replacing that hospital's 25-year-old ER with a larger, more modern facility. He might do well to read the article by Dr. Tom Meyer, chief of emergency medicine at Kaiser San Rafael, who describes the detailed planning that went into the design of his new Emergency Department, in order to be able to provide seamless patient-centered care for individuals with a multitude of conditions. Dr. Veronique Au tells us about Novato Community Hospital's ED and its acute emergency stroke program.

At the other end of the stethoscope, otolaryngologist Dr. Sal Iaquinta reports on the care he experienced in the Emergency Room and hospital following a bicycle accident, including his discovery that humor and stoicism don't always work to the patient's advantage.

From the public health/prevention side, looking to keep people out of the ER, Marin County's public health officer, Dr. Matt Willis, writes about the role of the medical society in supporting gun-violence research and evidence-based gun control laws, as well as in supporting physicians in their ability to screen families for guns in the home and counsel them about the safe handling and storage of firearms.

If all this sounds overwhelming, you might want to read the book *A Fearless Heart*, reviewed in this issue by Dr. Naveen Kumar, about cultivating compassion, starting with compassion toward ourselves, to prevent and reverse burnout. And that's a good thing to avoid since burnout—like the engine flameout that triggered Sully's emergency—can have unpleasant consequences.

The issue concludes with four CMA-related items. First, a report on the presentation to MMS president, Dr. Peter Bretan, of the Adarsh S. Mahal, MD Award at the annual CMA Gala. Then a 2016 House of Delegates Report, followed by a listing of CMA's Solo and Small Group Practice Resources. Finally, Dr. Bretan reports on CMA's advocacy efforts on behalf of physicians on the issue of inadequate insurance networks and the tension between out-of-network physicians being paid equitably for their work and patients being protected from "surprise bills."

All in all, this issue of *Marin Medicine* is just what the doctor ordered for physicians who'd like to think about a range of challenges outside the office. ◆

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Will It Be There When You Need It?

Myles Riner, MD

Sooner or later, you will need the ER. I don't care how healthy you are, how much you hate going to the hospital for care, how much you distrust doctors or modern medicine, how rich you are or how deep in the woods you live. The odds are almost 100% that in your lifetime you will end up in the ER. You may get lucky, and find yourself in a hospital that is staffed by highly qualified emergency physicians, backed up by a full roster of highly trained specialists and a bevy of great nurses, technicians, and the latest in diagnostic equipment and sophisticated operating rooms and ICUs and cardiac cath labs and all the rest. But don't count on it. The odds are pretty good that in the very near future this is not what you will find. In fact, in many areas of the country, you may not be able to find this right now. Why is that?

Emergency Departments (ERs) and the folks who provide care in these facilities are generally devoted to meeting a mission, actually, several missions. Providing care to everyone, 24 hours a day, 365 days a year, regardless of insurance status or ability to pay for this care is one such mission, perhaps the most important one.

Dr. Riner, of Mill Valley, is a retired emergency physician who worked at Marin General Hospital. This article first appeared on his blog, The Fickle Finger (www.ficklefinger.net/blog) in May 2016.

Artwork by Chris Blum, blumboxart.com

Another is providing surge capacity (the ability to gear up and staff up to meet sudden, unexpected surges in demand) in response to disasters, multiple casualty incidents, terrorist attacks, epidemics and pandemics, and the everyday situation where serious illness or injury strikes lots of different individuals in a community in a very short time span.

A third mission involves serving as a safety net for unfortunate members of the community who have no place else to turn for help—no readily available family, no outpatient psychiatric service, no safe place to shelter, no protection from abuse.

Another mission of the ER is to serve as the urgent diagnostic referral center for the entire medical system, allowing office-based physicians (and sometimes even hospital inpatient services) to send patients in for evaluation and stabilization without having to disrupt their office practice and abandon patients who have been waiting for their scheduled appointment.

Surprisingly, one of the missions of the ER is to keep patients *out* of the hospital by providing observation care and stabilizing treatment that often avoids the need for more expensive inpatient care. Patient education, coordination of post-discharge care and follow-up, surveillance monitoring for contagious disease, even preventative care: all are part of the mission of the ER.

With so many roles to play, so great a need for flexibility and preparedness, and so wide a range of services and skills that must be mastered and dispensed, is it any wonder that visits to the ER continue to grow year after year, or that the number of hospitals able to meet all these missions has shrunk by the hundreds over the last decade?

You might wonder why a facility like the ER that is so critical in so many ways to our communities is disappearing at such a rate, and why excellence in fulfilling these various roles is getting harder to find, or rely on. *There are many reasons for this, but the underlying fundamental reason is that no one wants to pay to ensure that these missions are met.*

Health plans don't feel responsible for helping hospitals and emergency care providers to meet these missions. Legislators don't want to put their re-election at risk by mandating funding or payment for these services. Insurance regulators aren't willing to require health plans to fund these services lest they lose the chance to work in the future for the insurance

companies they currently regulate. Consumer advocates and advocates for the poor want these services for free, or at the lowest possible cost, ignoring the fact that their constituents often rely on the ER as the only place they can reliably get the care they need. Many hospitals are living with such small margins that they just can't afford to subsidize the ER to meet all these missions.

In this world, we get what we pay for, and if we aren't willing to pay, we may not get anything. No one wants to pay anything more than the bare minimum for the actual care they receive in order to help the hospital and the ER staff meet all these missions: not the health plans, or the employers, or the consumers, or the government. Yet the government *mandates* that all these missions be met, particularly the first and most important, but in fact all the others, too. Talk about being caught between a rock and a hard place.

Maybe some of these missions can be met at lower cost—through greater efficiency, through sacrifice, through higher quality and fewer mistakes, through pension reform and union busting, through better technology and computer-driven information systems and volunteerism and telemedicine and all sorts of cost-effective care policies. We should try and currently *are* trying many of these approaches (though I would definitely not support all of them), and in fact many emergency physicians and nurses have worked very hard to implement cost-effectiveness in the ER. However, it isn't nearly enough to make up for the way third-party payers are ratcheting down reimbursement for ER care. As a result, this care will suffer, and already has.

If you need ER care—and you will—or if, heaven forbid, disaster or terrorism strikes and we *really, really* need our ERs to rise to the occasion (as seems to happen nearly every week), don't be surprised if your local underfunded, understaffed, undersupported, underprepared and regularly overwhelmed ER fails you. And don't blame emergency care providers. They are pedaling as fast as they can, and they warned you. ◆

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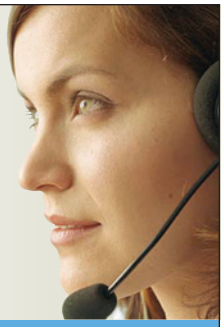

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What if Primary Care Was as Easy to Access as the ED?

Veronica Jordan, MD, MS

If you are feeling sick and drive down a decent-sized road in a decent-sized city in the United States, you will eventually encounter a blue **H** sign indicating a nearby hospital. If you follow that **H**, you will soon see a large red **EMERGENCY** sign. And if you walk into that Emergency Department, regardless of your insurance status, regardless of your immigration status, regardless of the nature or severity of your illness, you will be seen. It may be 3 a.m. or 3 p.m., a weekend or a weekday, a private hospital or a public one. You may have money or you may not. You may have to wait one or two or 10 hours. But you will be seen.

If you are similarly ill and don't want to visit the ED, the path isn't so simple, and the signs aren't so obvious. If you don't have insurance, the problem is dire. If you are undocumented, even more dire. But having health insurance is no guarantee. Identifying a primary care office that is accepting new patients is its own challenge. Many local clinics have six- to eight-week waiting lists for "new patient" appointments; others are at capacity. If you *do* have a primary care physician, there is no certainty that you will be seen today or even this week. You may spend an hour on hold waiting to talk to someone who may ask a few questions and then offer you an appointment for next Thursday. That same person may verify your insurance and inform you that it is no longer accepted or that your concern does not meet criteria for the limited urgent-care appointments available. She may direct you to the ED after all.

Dr. Jordan is a family physician at Sebastopol Community Health Center.

National statistics show that about 20% of American adults use the ED each year, and 7% have two or more visits.[1] Of those who are ultimately not admitted to the hospital, 80% say they used the ED because of access, 67% because of the seriousness of their medical problem, 48% because their primary care physician's office was not open, and 46% because they had no other place to go.[2]

EDs are designed to offer high-intensity response to acute illness and injury. They must be prepared 24/7 for trauma, natural disaster and whatever comes through the door. Unfortunately, a good percentage of the cases that present in EDs are not appropriate for emergency care, as they are either non-urgent, preventable or some combination of the two. Actual numbers are controversial (estimates range from 13% to 71%), but a recent study found that 59% of the reasons for which patients presented in an ED could have been attended to in a primary care office.[3]

ED care is also much more expensive than primary care: ED visits cost 320% to 728% more than primary care visits.[4] A 2013 study of 76.6 million visits found that the median charge for outpatient conditions in the ED was $1,233 (ranging from $740 for an upper respiratory infection to $3,437 for a kidney stone),

while the median price for an office visit was $145.[5] This difference in cost is partly due to the increased care offered in the ED (35% of patients who go to the ED get an x-ray, and 17% get a CT or MRI scan),[2] partly due to hospital billing, and partly due to the expensive spectrum of services that must be readily available in an ED in case of a true emergency.

Mental health and substance-use disorders (MHSU) account for 12.5% of visits to the ED.[6] These are often cases in which patients are treated and released over and over again, putting a tremendous strain on resources. Patients with coexisting mental health and substance abuse diagnoses are much more likely than people with diabetes or chronic respiratory disease to use the ED.[6] The more severe the mental health problem, the more frequent the ED visit; uninsured MHSU patients have even more visits.[6]

Patients seeking primary care and mental-health services in the ED put layered burdens on an emergency system that isn't designed to manage chronic illness, offer preventive care or provide continuity. As a result, EDs are overcrowded, overburdened and under-reimbursed (ED patients are more likely to be uninsured or self-pay, so up to 50% of ED claims are not paid), and ED personnel have little space or time to do what they do best. In short, our medical system spends a stupendous amount of money to care for patients in an utterly ineffective way.

What can we do in primary care to relieve the burden on EDs and ensure that patients are getting the right care in the right place?

The answer is simple. Patients need to have someplace else to go, and that someplace else should be their primary care physician (PCP). Most of my patients know that I am a better option than the ED, but heck, half of my family members and most of my friends still don't quite grasp the concept.

We need primary care embedded in our communities and our psyches. Last year, when one of my relatives got progressively shorter of breath over a period of months, she didn't once visit her PCP. Instead, she waited until she was so sick that she had to go to the ED, where she received a new diagnosis of heart failure. A few months later, she had nausea, vomiting and right upper-quadrant pain. Rather than calling her doctor, she again wound up in the ED—this time, flooded with intravenous fluids that were not great for her ailing heart.

In my relative's defense, her PCP's office is so overbooked, scheduling so clunky and triage so complex that they probably would have sent her to the ED anyway. Plus, she hardly knew her PCP. In a PCP-centered health system, this lack of familiarity wouldn't be the case. After all, we PCPs can handle shortness of breath and abdominal pain in the office, and we can often do it better than the ED because we know our patients, can see them again, and are uniquely equipped to prevent similar episodes in the future.

We need to show patients that having a relationship with a PCP will make them healthier and save them money, time and stress. But to do that requires several major overhauls. There need to be enough of us; we need to know our patients, teach our patients and be available to them; and we need to be creative in how we do all of this.

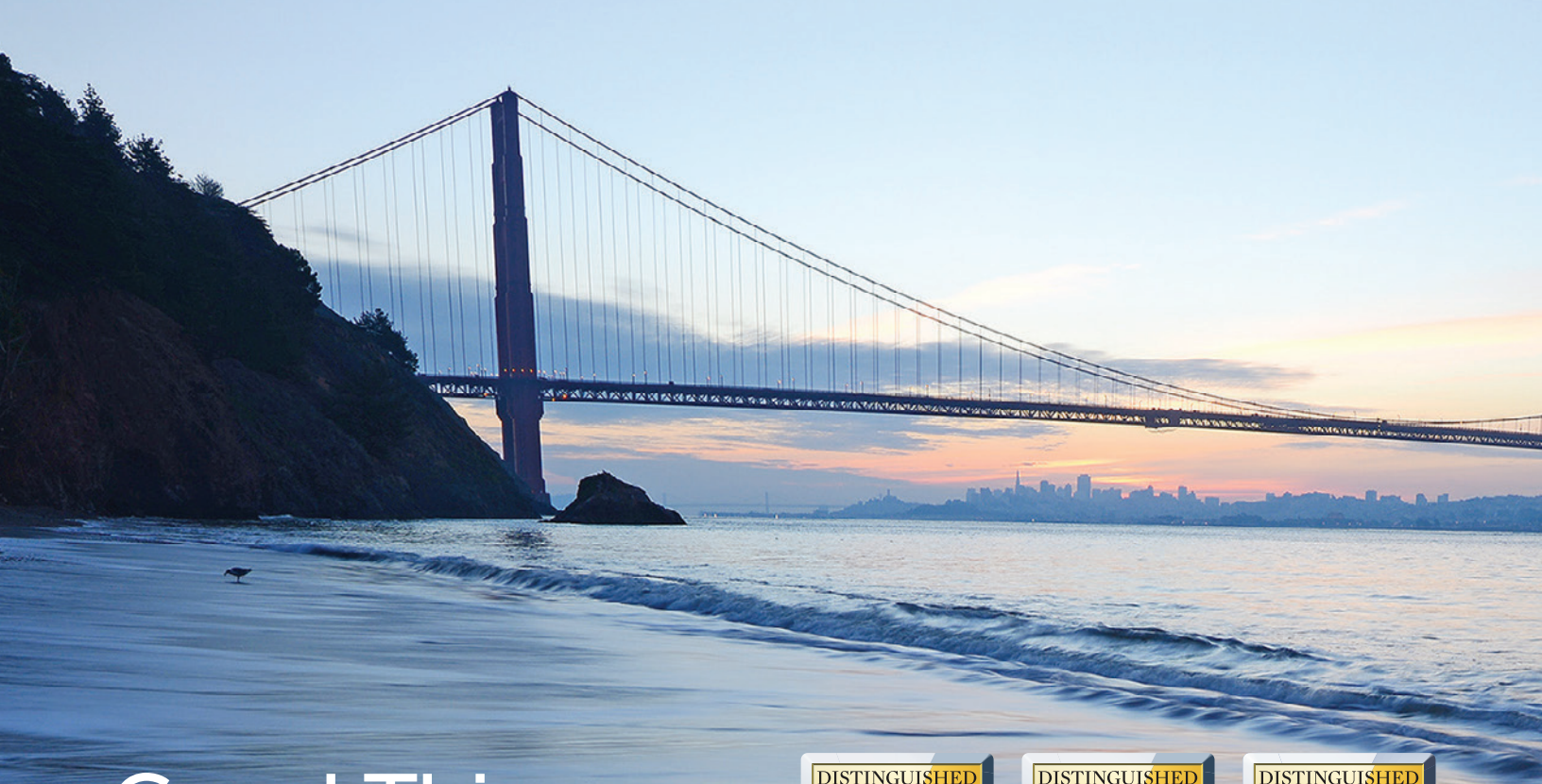
Implementation of the Affordable Care Act has increased the need for PCPs, so we need to enlarge the PCP pipeline by restructuring medical education. This restructuring should emphasize primary care instruction in medical school, foster health-center teaching, change the payment model of graduate medical education, and decrease the financial burden on physicians who choose primary care.[7–9] PCPs must create interdisciplinary teams instead of being dependent on individual physicians, and we must also welcome nurse practitioners and physician assistants to our table.[10] It is literally impossible for us to see the number of patients who need to be seen and do the work that needs to be done without partnering with these practitioners.[11,12]

Educating new providers is essential; educating our patients is even more important. Here is a basic question for patients: What constitutes an appropriate ED visit? The most common reason children visit the ED is cold symptoms; the top three reasons for adults are stomach pain, chest pain and fever.[1,3] Nobody should be visiting the ED for a cold, and most stomach pain does not require emergent evaluation or advanced imaging. But patients don't know that, and when they are ill, they get scared. We can teach patients about appropriate ED use, explaining what is truly an emergency, when they can wait until morning and what they can do in the meantime. We can do all this through office visits and creative media, such as public service announcements, school-based teaching and community health education.[13–15]

But to really keep patients out of the ED, we must have an established relationship with them and be available for reassurance when they are scared. I saw a very sick baby last month with bronchiolitis—he was as wheezy as they come. I know the mom well. She is also my patient; she trusts me. With my team's help, we saw her baby every single day for five days in a row, then every other day, then every third day. The baby got better, and mother and child never went to the ED, despite many friends and family urging them to go.

Truly robust primary care is a marriage of access and trust. We must increase patient access to trusted primary care teams on days, nights and weekends. Our primary care sites need to help patients avoid the ED by offering urgent care through extended hours (early mornings, late nights) and weekends. We need good follow-up with our chronically ill patients to catch them before they get acutely ill. We also need to have more freedom to "see" patients online or on the phone. Our current payment models force us to fill many visits with non-urgent matters, thereby taking up potential urgent-care slots. The payment models also shunt people to the ED rather than saving money and time by helping us attend to them in more creative ways.

When patients who overuse the ED are closely managed by a multidisciplinary team, their ED utilization decreases.[16]



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These patients respond to individualized care, case management, social work, housing and substance-abuse treatment. At West County Health Centers, we have been working with Partnership Health Plan on projects such as these, and we have seen success. Simple solutions—such as nurse advice lines, weekly medication organizers, home visits and crisis plans—do reduce unnecessary ED visits.

There are countless ways in which PCPs could do a better job of helping patients get the right care in the right place; but perhaps what we really need are signs on the highways and byways directing people toward primary care. Instead of a blue **H** for hospital, we could have an orange **PCP** for primary care physicians. And instead of a bright red **EMERGENCY**, we could have a healthy green **PRIMARY CARE.** ◆

Email: vcjordan@wchealth.org

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'TIME IS BRAIN'

Jonathan Artz, MD

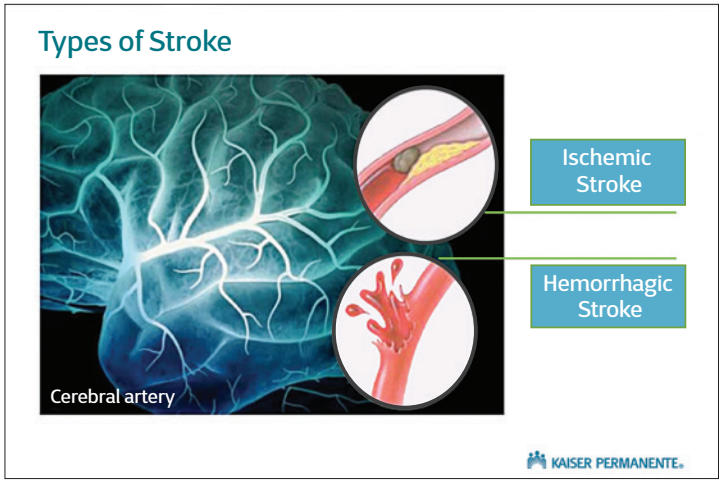
Stroke, the nation's third-leading cause of death and a leading cause of serious long-term disability, is a condition often seen in emergency rooms. Acute ischemic stroke, the most common type of stroke mechanism, is caused by a clot obstructing the flow of blood and oxygen to the brain, which can result in the death of brain cells.

The motto of health care providers who evaluate and treat stroke patients is "Time Is Brain." That is, every minute lost before the obstruction is cleared results in the oxygen-deprivation death of additional brain cells.

Thanks to telehealth equipment and techniques, including high-resolution video, providers can now gain precious time in evaluating and treating patients presenting with symptoms of stroke. In the Kaiser Permanente system in Northern California, we call this our Telestroke program.

The goal of a well-designed stroke program is to quickly address the blockage, either by administering tPA (tissue plasminogen activator, which dissolves clots) or by physically removing it.

tPA is the only FDA-approved treatment for acute ischemic stroke, and the sooner it can be given to a patient, the better the outcome in terms of functional recovery and reduced morbidity and mortality. This medication must be administered in the hospital as it is a potent clot-busting drug given by intravenous infusion. Recent advances in acute stroke management help patients who do not improve after tPA administration by extracting their blood clot with newly developed clot retrieval devices.



Kaiser's "Stroke Pathway of Care" involves Primary Stroke Centers (where tPA is administered) and Comprehensive Stroke Centers where medical personnel with advanced interventional radiology training are available to manage situations involving a large clot persisting in one of a few major arteries within the brain. Groundbreaking research in stroke management has made possible the introduction, in just the last two years, of several new clot retrieval systems. These thrombectomy studies[1–4] showed that removal of certain large clots within well-defined regions of specific brain arteries within a defined time window from the onset of the stroke episode can be safely performed. Such clot removal reduces major disability and greatly improves functional outcomes.

Kaiser's Telestroke program allows emergency physicians in any of 21 Kaiser hospitals in Northern California to alert a neurologist at a remote location—*often before the patient suspected to be having a stroke arrives at the Emergency Department via ambulance*. Diagnostic images of the patient's brain are made instantly available to both the Emergency Department and remote physicians electronically, and the neurologist can assess the patient visually with the help of video technology. All this shaves precious minutes off the time it takes to determine if the patient is a candidate for tPA. That drug, to be effective, must be administered within 180 minutes of the onset of stroke symptoms (with an extended window of up to 270 minutes if the patient meets certain criteria), and it is more effective the sooner it is delivered.

Kaiser's Northern California Stroke Express Program was established in 2015 and consists of a group of about 18 neurologists and neuro-critical care specialists from various facilities

Dr. Artz, a neurologist, is medical director, Stroke Services, at Kaiser San Rafael Medical Center.

Dr. Artz as "patient" with Dr. Peter Reidy, hospitalist and Stroke Services team member, performing a mock exam. On the right is the CISCO AVI video cart, with high-resolution zoom camera mounted above the screen panel.

throughout Kaiser's Northern California network. Each Stroke Express member rotates call coverage in a shift that typically lasts four to eight hours. The Telestroke neurologist on duty covers the entire Northern California hospital network and evaluates patients, both those being seen in a Kaiser ED and inpatients who suffer a stroke in any of these 21 Kaiser facilities. Some of the Stroke Express neurologists are part of a core group of six who spend over a third of their clinical time just performing Telestroke assessments. The other (non-core) members do fewer stroke "calls" per week.

The teleneurologist leads the way in ensuring the expedited evaluation of newly arrived patients in order to optimize the delivery of tPA in either the Emergency Room or an inpatient setting. The teleneurologist also communicates with the nearest Comprehensive Stroke Center when it is necessary to remove large clots using sophisticated mechanical clot retrieval systems.

Following is an example of a Telestroke team approach to evaluating and managing an acute ischemic stroke patient.

Patient Mr. B, age 62, with well-documented hypertension and atrial fibrillation (on daily aspirin), was sitting watching TV with his wife at 6:30 p.m., just after finishing dinner. He got up to go the kitchen when his wife noticed he was staggering to the right. His walking remained impaired. He could not communicate his thoughts, and most words did not make sense. She called 911 at 6:32, and EMS arrived at 6:40 to find Mr. B with an expressive and receptive speech/language deficit and difficulty in lifting his right arm. EMS called in a "pre-notification stroke alert" to the local (South San Francisco) Kaiser facility, which immediately led to a stroke alert activation for the entire stroke team at the Primary Stroke Center, including the Telestroke neurologist (who was sitting at the computer at home in Sacramento), the local South San Francisco neurologist, the radiologist, the CT technologist and the Emergency Department staff.

The patient arrived at the Emergency Department at 6:52 p.m. and was immediately met by the virtual Telestroke neurologist who had already reviewed his health record on the computer and verified his outpatient medication list. The Telestroke neurologist, with the assistance of one of the Emergency Department nurses, performed the NIHSS (National Institute of Health Stroke Scale) evaluation over the next five minutes—the score was 12 (out of maximum 42 points). Blood pressure was recorded, weight entered in the computer and the decision made to mix tPA. Mr. B, with his wife walking next to him, was escorted to the CT

scanner with the Cisco AVI Live Stream Camera alongside him on a cart pushed by the ED nurse. Once in the CT scanner area, the patient underwent a CT scan of the head, which the on-call radiologist read within two minutes and reviewed with the Telestroke neurologist.

The CT scan showed no evidence for intracranial hemorrhage (the presence of blood products would have been an absolute contrainidication to administering tPA) so the Telestroke neurologist led a "time-out" session where the patient was reassessed for the persistence of his neurological deficits and blood pressure was recorded (since hypertension over 185/110 is also considered a contraindication to tPA administration). The risks and benefits of tPA were reviewed with the patient's wife, who was asked for consent or non-consent to tPA administration. (Mr. B could not understand or reliably express his wishes about accepting or refusing tPA therapy.) The pharmacist who had mixed the tPA was standing next to the ED nurse, holding the tPA bag. Once the Telestroke neurologist gave the verbal order to "Go ahead and give tPA," the pharmacist, after verifying the appropriate patient identifiers, handed the tPA to the nurse.

After the initial bolus of tPA was administered, a one-hour infusion was begun. (The recommended dose of tPA [Activase®/alteplase] is 0.9 mg/kg, not to exceed a 90 mg total dose, infused over 60 minutes with 10% of the total dose administered as an initial bolus over one minute.) Immediately after the tPA infusion started, a CT-angiogram was performed over the next several minutes to view the blood vessels from the top of the aortic arch to within the brain, searching for a large vessel occlusion (LVO).

Because the CT angiogram showed a large clot in the Left Middle Cerebral Artery (M-1 segment), the Telestroke neurologist called for a Critical Care Transport vehicle to be ready to take Mr. B to the Comprehensive Stroke Center in Redwood City, about 20 minutes away, where a thrombectomy (clot removal) could be considered if the clot was still present and shown to be anatomically accessible on a catheter angiogram. Mr. B finished his one-hour tPA infusion, but his neurological deficits remained as he entered the angiogram suite at Kaiser Redwood City. Thrombectomy was attempted by a neuro-interventional radiologist, using a Solitaire Clot Retrieval System.

The patient was immediately taken to the ICU for post-tPA and thrombectomy nursing surveillance. One hour after the thrombectomy, Mr. B's speech was coherent but slurred and his arm strength had improved as objectively verified by the modified NIHSS score of 4.

This sequence is a typical example of the work flow and team dynamics that occur nearly every day throughout Kaiser's Northern California system in evaluating and treating patients with acute ischemic stroke. ◆

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Providing Comprehensive Service to the Community

Jeffrey "Jim" Dietz, MD

Artist's rendering of the new hospital emergency entrance.

The Emergency Department at Marin General Hospital is proud to provide outstanding, comprehensive care to our community. Like the other departments at our hospital—some of which offer services, including neurosurgery, OB, psychiatry, pediatrics and cardiac surgery, that are not available elsewhere in the county—we are blessed to have an excellent medical staff and a dedicated corps of nurses and other staff members.

When the current Emergency Department opened in 1991, it seemed cavernous compared to the tiny facility we had been using before that. In the 25 years since then, the limitations of this space have become increasingly apparent. As the services we offer have grown in number and complexity, the physical plant, in response, has expanded in piecemeal fashion. Not only do we now feel the current space is inadequate to our patients' needs, but we realize that the geometry of our campus is less than ideal. For instance, a trip to the CT scanner involves an elevator ride and passage down a long hallway. And, although our door-to-cath-lab time for acute STEMI averages 45 minutes (half the national average), that trip involves an even longer transport of a critical patient.

We are also keen on our patients' experiences of care. Five years ago we opened our Rapid Medical Evaluation (RME) area, which has improved patient flow and decreased wait times. We have opened a new patient reception area (what used to be called a waiting room) and remodeled provider and patient care areas to make them more efficient, comfortable and attractive.

But the *big news* is that in four years we will be moving into an Emergency Department that has been designed as part of MGH 2.0, our new hospital!

In the new Marin General Hospital, the Emergency Department will be three times its current size. Each patient room will be private with walls and sliding glass

Dr. Dietz is medical director of Emergency Services and chair of Emergency Medicine at Marin General Hospital.

doors, and twice as large as current treatment areas. No more gurneys separated by curtains! Each room will be equipped with state-of-the-art technology, ergonomically installed, so that physicians and staff can provide safe and efficient care.

We have placed an emphasis on patient experience so the space is designed to shield patients and their families from unnecessary sensory experience—those sights, sounds and smells that can make an Emergency Department visit far more uncomfortable than it needs to be.

For patients who come in under special circumstances, such as those who need to be accompanied by security or law enforcement, we will have a separate entrance area and an isolated treatment area. From the Ebola scare, we have learned a great deal about the importance of isolation and have created two appropriately sized and configured treatment areas should such an epidemic come to the Bay Area. We have also designed safe holding areas for psychiatric patients, whose needs are quite different from others we treat in the Emergency Department.

What is really exciting to me is that the entire structure of MGH 2.0 is designed so that there are proper adjacencies of services. Accessing the CT scanner (actually two) and other diagnostic imaging services will require passing through just one set of doors. The trip to the cardiac cath lab will shrink to less than a minute.

It has been my privilege to have been a part of the Emergency Department team at Marin General Hospital for the past 27 years. We have, during that time, expanded our services and provided state-of-the-art, comprehensive care to the patients we serve. I am confident that MGH 2.0 will be an important enhancement to the well-being of the people of Marin. ◆

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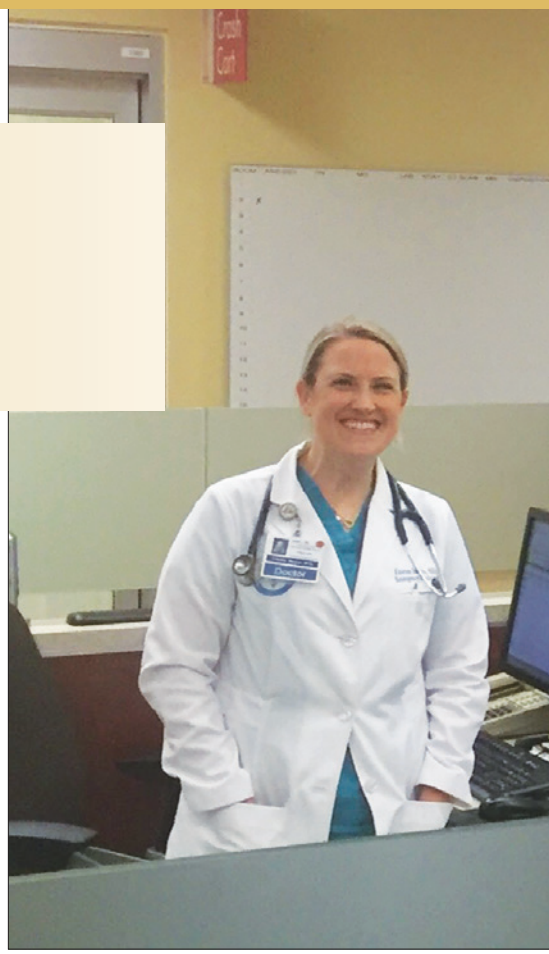
Creating a New, State-of-the-Art ED



Thomas Meyer, MD

Kaiser Permanente physicians first opened medical offices in San Rafael in 1958 on the 4th Street "Miracle Mile." In the early 1960s we bought the wooden A-frame structure at 99 Montecillo Road in Terra Linda. When our existing hospital at that site opened in January 1976, the Emergency Department was state-of-the-art. But the practice of medicine is ever-evolving, so when I came to San Rafael straight out of residency in 1992, the ED was already showing its age. This was especially evident as I'd had the good fortune to move into a brand-new, 60-bed ED in the second year of my residency in Cincinnati.

Plans to remodel or replace the ED had been on the books at least five years before I arrived. New versions were drawn, then scrapped at least four times over more than 20 years. And while I am very proud of the great care we've always given our patients, for much of my career it seemed we did so despite our physical layout. So when we finally received the green light in 2009, we were very excited to begin, from scratch, on plans for an all-new ED.

Dr. Meyer is chief of the Department of Emergency Medicine at Kaiser San Rafael Medical Center.

From the outset we felt extensive user input would be crucial for success. To their credit, the architects were more than willing to collaborate. Thus, my managers and I were given near total control over all aspects of the design, as long as we stayed within the approved size and scope of the project. Throughout the process we had guidance from our outstanding in-house development team headed by Willa Jefferson-Stokes.

The most obvious thing we needed was more space (the old department was 7,000 sq. ft.; the new one is 17,000 sq. ft.). Simply following modern hospital building codes delivers more space. The key, however, is to make sure it's organized in a way that allows you to deliver optimal care. There were many issues to address.

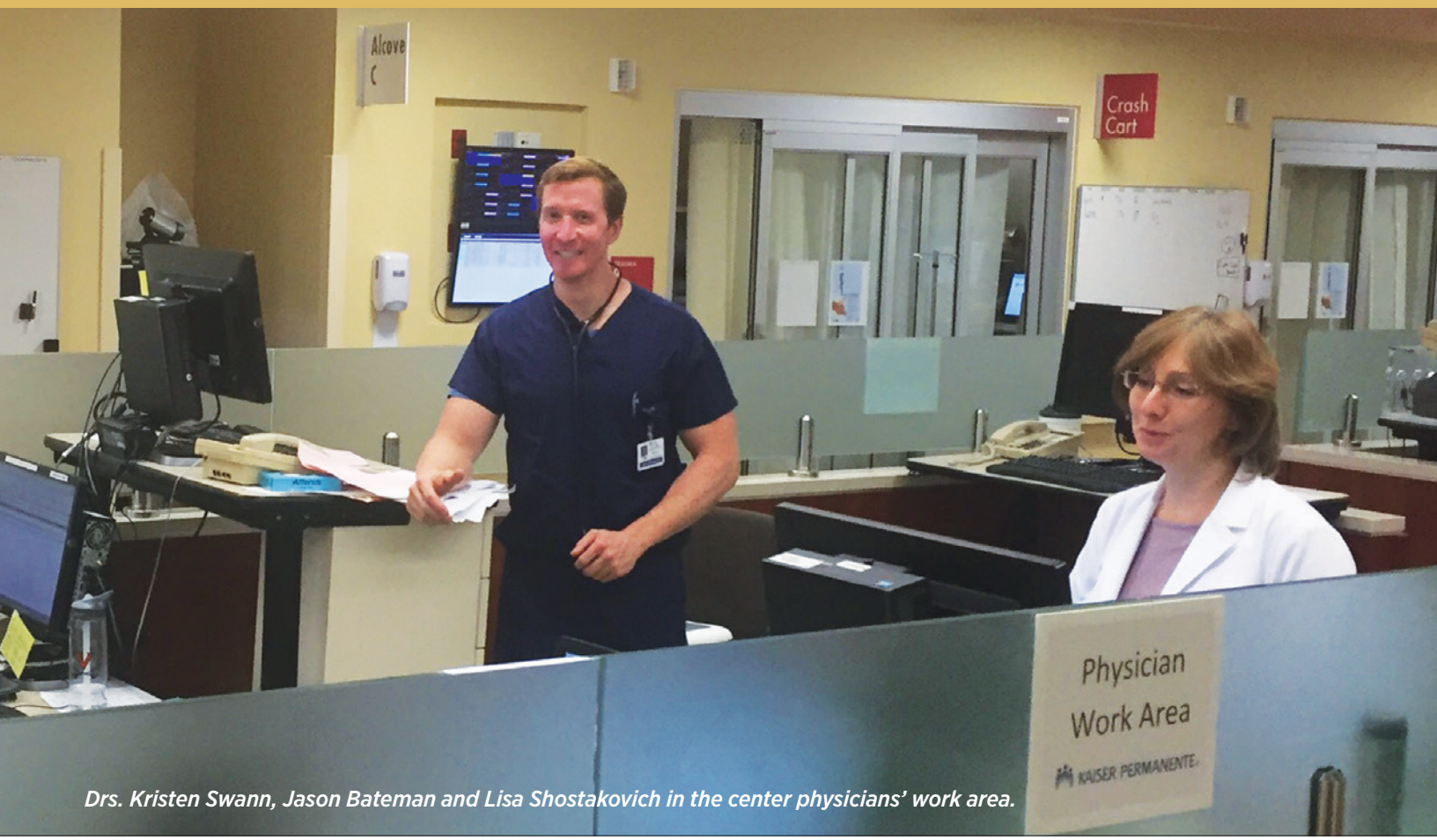
Standardize room design

In the old ED, each room was unique. While this might add charm to a bed-and-breakfast, it's a real pain in an ED, and as health care professionals, we always look to minimize pain. Some rooms had two beds, some had one. Some had a monitor and medical gases, some did not. A few had overhead procedure lights but most did not. Equipment in one room was not likely to be in the same place in any other room. Whatever was needed, you always had to think twice to find it. This wasted precious time and energy many times on every shift.

In the new ED, every room is private. Except for minor variations made necessary by columns and bracing, nearly all rooms have an identical layout and equipment. Even special-purpose rooms such as trauma, GYN, negative pressure and ENT/eye rooms hew closely to the layout principles of the standard rooms. Thus, physicians and staff don't have to reorient each time they enter a room. This greatly facilitates patient care as well as the stocking of rooms.

Organize rooms for optimal patient care

Removing barriers to optimal patient care produces better care. And what is more important for safe patient care than effective hand hygiene? Left to their professional instincts, architects like to save on plumbing by having sinks share a wall between rooms. Yet because physicians are trained to always examine from the patient's right side (to do otherwise is



Drs. Kristen Swann, Jason Bateman and Lisa Shostakovich in the center physicians' work area.

like trying to play a guitar backwards), if the sinks were placed according to the architects' training, half the time doctors would have to cross the room to wash their hands before and after an exam. Less hand washing could result. If hands are always washed as they should be, precious time and energy would be wasted. In the new ED, the sink is on the right side of the gurney, just inside the entry to every room. No time wasted. Clean hands always.

Patients are more comfortable when a physician is sitting at the bedside rather than towering over them. Studies have also shown that patients perceive that a physician who sits spends more time with them than a physician who does not, even when they are in the room for exactly the same amount of time.

In the old ED, rooms were cramped, cluttered and outdated, so sitting at bedside was often not possible. The new ED provides dedicated space for physicians and nurses to sit at the patient's right side. This space has an adjustable-height exam stool and is clear of any potential obstructing objects such as IV poles, monitors, computers, patient warmers and storage bins, all of which are mounted on the walls. Family has dedicated seating on the opposite side of the gurney to avoid the awkwardness of a seated person being displaced.

Computers, now essential to effective medical care, have become omnipresent in the exam room. However, they can take your focus off the patient. We wanted to mitigate that so we used wall mounts selected for their ability to allow the monitor and keyboard to fit onto the user's lap. While the computer folds nearly flush with the wall, it extends up to six feet into the room when in use. This makes it possible to access our robust electronic medical records from a patient-friendly seated position, making frequent eye contact while taking a history. Wall mounting also frees floor space to stow the Mayo stand under the computer, which keeps the bedside uncluttered.

Placing items needed for patient care in a consistent and easily accessible place in the exam room also facilitates great patient care. This includes items the physician needs such as otoscope/ophthalmoscope, tongue blades, guaiac cards and reflex hammers as well as nursing items such as Band-Aids, glycerin swabs, urinals and 4x4s. With so many items in every room, order is paramount (more on this below). Everyone's job is easier and gets done more reliably if supplies are always readily at hand.

Make rooms universal to avoid bottlenecks in flow

The old ED had rooms for low-acuity patients and rooms for high-acuity patients, rooms for patients needing procedures and for those who did not. If the patient flow did not match the room mix, a bottleneck resulted, even when the department was not full. Suture rooms were a particular problem as we had only two.

***Left:** The "airway command center"— an unobstructed path to the head of the bed for critical care in the trauma rooms.* ***Right:** Provider zone on the patient's right side. Access to linen cabinet, sink, gloves, sharps containers, tilt bins, computer and IV pump facilitates efficient care delivery.*

***Left:** Family zone on the patient's left. Folding chairs, belongings bags and clothing hooks. A comfortable place for loved ones outside the work zone.* ***Right:** The ENT/eye room. A very different mission, but the central theme is preserved: provider zone and family zone.*

In the new ED every room has an overhead procedure light, full monitoring capability, med gases and suction. Except for the ENT/Eye room, with its specialized equipment and supplies, every room is set up for nearly every type of patient complaint. Three mobile procedure carts are dispersed strategically around the department and can turn any room into a suture room.

Create distinct work and family zones in each room

In the old ED, lack of consistent room layout caused staff and visitors to frequently bump and apologize for being in each other's way.

In the new ED, the left side of the room (to the patient's right) is set up as the "work zone." The right side is set up for family/visitors. The head wall (and thus the gurney) is slightly biased to the right to give ample room for a doctor and nurse to work (on the left side) simultaneously. This extra space also facilitates bringing EKG and ultrasound machines to the bedside. Because the sink is always on the left in the work zone, hand washing never means moving very far or asking family to move. Linen/supply cabinet, sharps containers and wall-mounted "tilt-out bins," which hold all the items needed for patient care, are also in the work zone.

The right side of the room is optimized for visitors. Two folding chairs are provided in the right rear corner. This comfortably positions visitors at the bedside but out of the way of physicians and nurses. Clothing hooks with belongings bags mean that Mayo stands and exam stools don't get used for this purpose. There is a TV in the left front corner of every room, with the speaker and control on the nurse-call device, allowing volume to be kept to a minimum.

While TVs are a great patient satisfier, their real value lies in the future. We hope to connect the TVs to the electronic track board someday. This will turn them into real-time status boards keeping patients informed of the names of their care team and what tests are pending. In the future they will also bring instructional videos to the bedside.

Encourage physician collaboration without creating a barrier between physicians and staff

A space for physician collaboration was a feature of the old ED that we wanted to keep. A physician workroom allowed up to six ED docs and consultants to work side by side. This encouraged a natural clinical collaboration. Thus, patients with challenging problems benefited from collective experience. It also contributed to professional satisfaction and prevented isolation and its attendant burnout.

In the new ED we wanted to maintain and improve upon this. We provided a work area with eight stations at the center of the ED core, partitioned by a half wall. This provides physicians with privacy while seated but a view of the entire critical care area when standing.

The old workroom, completely enclosed by full-height walls, had a single door. This tended to separate physicians from nurses and created an area that some staff found intimidating. The new area is open on two ends and is much more comfortable to enter. In addition, nurses and physicians can easily communicate over the half wall, kept to 52 inches for that purpose. The physician work area is flanked on both ends by nursing workstations. This arrangement greatly enhances communication.

"A place for everything, and everything in its place"

While I am no fanatic for organization at home, at work, I have to be. With approximately 120 people sharing a workplace, there is simply no room for individuality when it comes to where to put things. Without order there is chaos.

A new department space was a great opportunity to create order. Every drawer and shelf is compartmentalized to hold a single item type. Every bin is labeled. Items frequently needed in the treatment rooms are stored in clear, wall-mounted tilt-out bins or in the linen cabinets. Less frequently needed items are stored in the clean utility room on large carts or shelving units.

Small minor-procedure carts are dispersed throughout the department. Alcoves are abundantly provided so these carts do not sit in the hallways. Stackable wheelchairs are stored "grocery cart style" in alcoves in three corners of the ED so they are always at hand but do not clutter up the department. Similarly, EKG machine, ultrasound units, suture carts, crash carts and even hall gurneys have dedicated, labeled alcoves.

In the resuscitation rooms there are airway carts and critical-procedure carts. These are "stocked and locked" with an individual tear-away lock on each drawer so that, at a glance, nurses can see that their rooms are ready for critical patients.

In every room there is a rectangle of different-colored flooring indicating exactly where to position the gurney. In the resuscitation rooms, this means the gurney is always four feet from the headwall. This, and the strategic running of all IV, O_2 and monitoring cables from the left side mean that a physician always has an unimpeded path to the head of the bed for critical airway management.

Other features

Just behind the greeter desk are "rapid care rooms." There, patients with minor problems can be treated without being brought into the hustle and bustle of the main treatment core. A family conference room, also outside the core, is designed to provide a warm, non-clinical feeling for sensitive conversations between family and staff. An administrative wing accommodates management offices, a lounge, staff lockers, restrooms, showers and a conference room for meetings and education.

While it was long in coming, we think our new ED is a model for providing optimal, efficient patient care. If you have occasion to need it, we hope you will agree! ◆

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World-Class Emergency Care That's Close to Home

Veronique Au, MD

The Novato Community Hospital Emergency Department is committed to providing high-quality, compassionate care in the community setting. By incorporating technological advances such as a robust electronic medical record, telemedicine consultations and the latest in diagnostic equipment, our emergency physicians have all the resources they need to provide patients with the same quality of care found at larger medical facilities while offering the personal attention to detail and friendly service our community hospital is known for. Combining this with the resources of Sutter Health's 27-hospital system offers patients the benefit of close-to-home access to world-class comprehensive emergency care.

A prime example of this level of care coordination is our acute emergency stroke program. Novato Community Hospital is a proud recipient of The Joint Commission's Certificate of Distinction for Primary Stroke Centers. (An independent nonprofit organization, The Joint Commission is the nation's oldest and largest health care standards-setting and accrediting body.) In coordination with the world-class stroke neurologists at Sutter Health's California Pacific Medical Center in San Francisco, all patients presenting to our Emergency Department with stroke symptoms receive the same extraordinary level of service close to home that they would in San Francisco. Emergency physicians at Novato are able to initiate testing and treatment while simultaneously involving the California Pacific Medical Center Stroke Team. Dedicated telemedicine monitors connect stroke neurologists in San Francisco with colleagues in the Novato Emergency Department, offering immediate consultations and the best possible outcomes for stroke patients.

Novato Community Hospital has also earned The Joint Commission's Gold Seal of Approval® and the American Heart Association/American Stroke Association's Heart-Check mark for Advanced Certification for Primary Stroke Centers.

We strive to make giant leaps forward in the safety, quality and affordability of health care in the U.S. by promoting transparency through our data collection and public reporting initiatives.

Technology is paramount to providing leading-edge care, and Novato Community Hospital provides advanced care when and where it matters. Advanced-technology imaging and state-of-the-art laboratory and surgical capabilities provide excellent care to the patients we serve. Yet how care is delivered is also a key aspect of successful patient outcomes. One of the key factors that makes the Novato Community Hospital Emergency Department a favorite among North Marin residents is the friendly, compassionate, quality care patients are sure to

Dr. Au is vice chief of staff at Novato Community Hospital, where she is also co-medical director of the Emergency Department and Urgent Care.

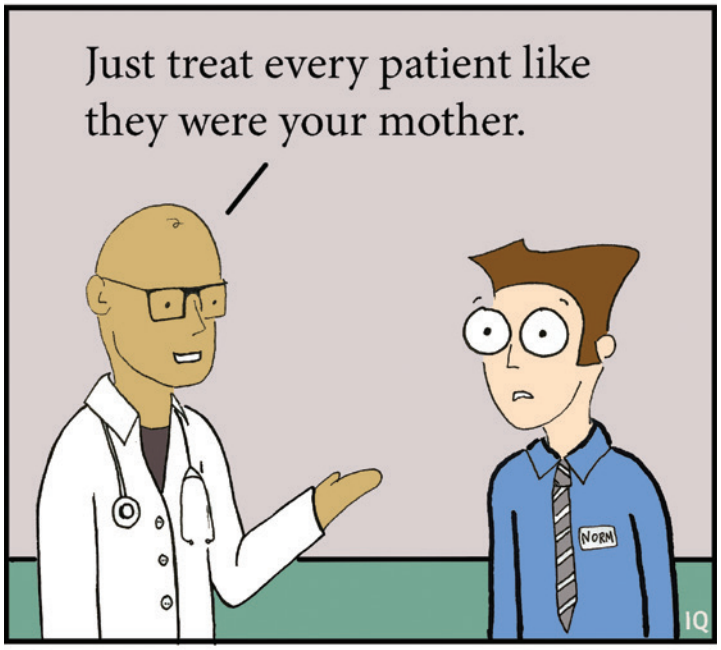
receive. Many of our long-term, dedicated staff grew up in Novato and have been practicing medicine for over 20 years. Emergency room staff members know many of their patients like family because our patients often are parents, children or neighbors of the medical staff caring for them. The unmistakable community connection here makes a true difference in the patient experience.

Novato Community Hospital is located on a 10-acre Sutter Health Medical Campus on the border of a wetlands area near the intersection of highways 37 and 101. Key features for a sustainable health care facility include energy conservation/landscaping, non-toxic building materials, recycling and waste management, ambient interiors and healing landscapes. The hospital operates a 24-hour Emergency Department, inpatient/outpatient surgery, orthopedic surgery, total joint replacement surgery, a medical/surgical unit, a critical care unit, imaging services, outpatient laboratory, and a physical therapy and sports fitness center. ◆

Email: auv@sutterhealth.org

Experiencing the ED from the 'Other Side'

Sal Iaquinta, MD



"The very moment Norman Bates decided to drop out of medical school and open a motel." — *Cartoon by Sal Iaquinta*

The doctor as patient is nothing new. In fact, it's impossible to avoid. But, boy, can it be an eye-opening experience.

Without going into too many details, let me start with "The bicycle helmet did its job." I managed to crack both the front and back of it, but I didn't pass out or get a concussion or even a headache. In other words, I was lucid for the entire hospital experience.

The first lesson learned was one I'd heard a thousand times. *It's hard to overcome first impressions.* This is sometimes reworded to the front desk staff as *You are the first face a patient sees. You shape their care experience.* Unfortunately, the man at the ER entrance, when asked by my girlfriend to help me out of the car, replied with exasperation, "Well, how did he get into the car?"

Fail.

The point of this article is not to malign the very place I work for, but it would be disingenuous to mention only the bright spots. My experience also helped me realize that as a physician I never spent much time thinking about what happens before and after I'm in the room with a patient. As a patient, however, I got to witness the entirety of the experience.

Dr. Iaquinta is a San Rafael otolaryngologist.

Perhaps the second lesson of the adventure is that of Patient Personality. During medical training we are told that "the hypochondriac will die of something . . . take every complaint seriously until proven otherwise." The Stoic Patient is almost the opposite: "The patient that complains of nothing will die of something . . . so what are they here for?"

I add the joker element to stoicism. I'm guilty of keeping quiet, even in severe pain, and I'm guilty of bad jokes. Yes, I confess I told the nurse who asked if I was willing to accept a blood transfusion, "No, because then I can't time travel back to yesterday and undo this." It only makes sense if you've seen *Edge of Tomorrow* and latch onto the nerdy time travel rules. Like I said—"bad jokes." Antics like these, along with otherwise keeping quiet, meant I slowed the discovery of my internal bleeding and numerous fractures. In my situation, time was not of the essence, so no big deal. But it did make me realize that I've seen a number of jokesters. And even more minimizers, some to such a degree that their chief reason for coming to the hospital is "because my wife sent me." Sometimes it's "husband," but in my experience wives do more of the sending. Regardless, these patients demonstrate that the medical history might not be as fruitful as the medical exam.

The third lesson is that of empathy and caregiving. I interacted with no fewer than 15 health care workers in the first few hours of my hospitalization. One of the standouts was a young phlebotomist—her visit epitomized the ideal health care interaction. She was efficient without rushing. She was focused on me; there was no one else in the universe waiting for blood to be drawn. She expressed regret

that I was there that day. She explained every step of what she was doing—no surprise needle pokes. I felt she took pride in her job and actually cared about me. Whatever it is that gave her those qualities, I wish I could bottle it and sprinkle it over the entire planet. There had to be something more than focus and patience, but those are two good places to start. Can I walk into a patient's room and leave the rest of the busy world outside the door? She showed me it's worth trying.

My next observation isn't really a lesson. But I realized how much of an art nursing is. It takes empathy plus a whole lot more to care for a group of unwell people. My nurse was part cheerleader ("You can do this."), part coach ("OK. This is how you can get out of bed without hurting your ribs."), part negotiator ("If you don't get out of bed, you have to use this bedpan." I got out.), part servant ("Is there anything I can get for you?"), part drill sergeant ("Stop! And give me 20 on the incentive spirometer."). And it's all delivered with kindness, all day long, to multiple patients. I thought my fatigue was a side effect of the narcotics, but the more I think about it, the more I believe it was from watching the nurses run around.

When you put it all together, you realize that the delivery of health care isn't a well-oiled machine. It needs to function like one, but really it is a play with an ensemble cast taking place at a dinner theater. The patients are both participants and audience, watching the entire time. Every second. And just like a play and its actors, the hospital staff can't drop out of character, forget their lines, or be dismissive of their patrons.

This sounds like a lot of pressure, being "on" all the time, but that's what it is. And the stakes are higher and harder to accomplish than those of a dinner theater; we aren't wowing people out to have a good time with well-timed jokes and good food. We are trying to help people having a rough time . . . perhaps the worst of times.

But all that said, it's worth the effort to put a smile on their faces. That's why you went into medicine. ◆

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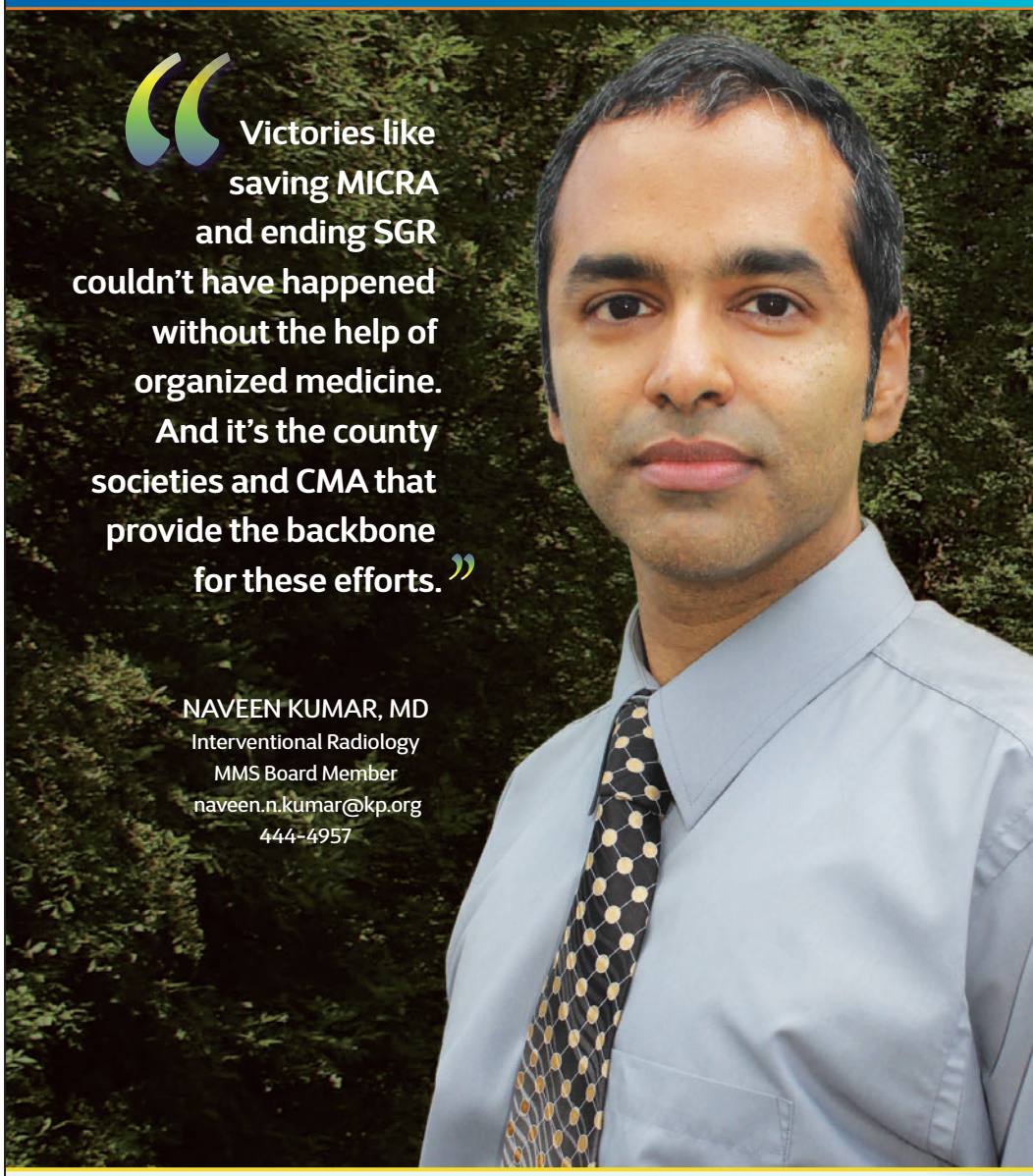
"Victories like saving MICRA and ending SGR couldn't have happened without the help of organized medicine. And it's the county societies and CMA that provide the backbone for these efforts."
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Marin County gun buyback program: helpful, but to make Marin safer, much work remains to be done.

GUN VIOLENCE AND PUBLIC HEALTH

Matt Willis, MD, MPH

Because the theme of this issue is Emergency Medicine, it seems appropriate to address one of the most important preventable sources of injury and death in America today. According to the CDC's National Center for Health Statistics, gun violence kills more than 33,000 people a year in the United States, nearly as many as motor vehicle accidents.[1] The Marin Medical Society, the California Medical Association and the American Medical Association have long advocated reasonable and responsible gun control legislation to make our communities safer and hospitals less crowded.

Many are calling for gun violence to be seen as a national public health priority. What do we gain by framing gun violence as a public health issue, in addition to a law enforcement and public safety issue?

Dr. Willis is Marin County's public health officer.

First, as a branch of health science, public health relies on research and data to inform practice. This can lift dialogue out of entrenched partisan lines and elevate evidence-based understanding. The available data is sobering.

In California, 2,900 people died by firearms in 2013. About half were suicides (54%), the other half (45%) were assaults.[2] Another 2,650 were hospitalized and survived, and 3,385 went to the Emergency Department and survived.[3]

Unfortunately, longstanding restrictions on the ability to research and monitor the role of guns in deaths and injuries make it difficult to measure their true impact and refine our strategies. In June, AMA President Dr. Steven Stack said, "Even as America faces a crisis unrivaled in any other developed country, Congress prohibits the CDC from conducting the very research that would help us understand the problems associated with gun violence."[4]

When research is conducted, the scope of the problem becomes clearer. A recent *JAMA* study described[5] 29,000 Denver-area emergency department patients treated for gunshot wounds between 2000 and 2013 and found that the fatality rate increased significantly over that period. The authors concluded that guns are "becoming progressively more dangerous." Research like this is invaluable in guiding policies regarding access to particularly deadly classes of firearms.

A study published in *NEJM* found that living in a home where guns are kept increased an individual's risk of death by homicide by between 40% and 170%.[6] Another study published in the *American Journal of Epidemiology* similarly found that "persons with guns in the home were at 90 percent greater risk of dying from a homicide in the home than those without guns in the home."[7] Such findings add an evidence-base for clinical practice to screen families for guns in the home and counsel on their safe handling and storage.

Instead of waiting for a federal response to the call for high-quality

research, California and other states are taking action. Senate Bill 1006, passed this summer, will fund a new gun violence research program and center at UC Davis. The program will focus on both the causes and consequences of gun violence as well as the effectiveness of existing laws. A $5 million appropriation will fund the gun violence center's first five years of operation.

The CMA and the Health Officers Association of California strongly supported the bill. CMA President Dr. Steven Larson said, "SB 1006 creates a research center within the University of California that will allow this state to do this very research and provide California with the analysis it needs to fully address this public health crisis."

Beyond highlighting the need for research and data-driven solutions, a public health approach to gun violence acknowledges the array of factors behind this complex epidemic. In national dialogue following the recent Orlando massacre, three dominant themes have emerged regarding preventing mass shootings. While some focus blame on one or another of these issues, each must be addressed simultaneously and in parallel before we can feel safe from the threat of firearms.

These themes are (a) guns—including their availability, design, sales, regulation and capacity for harm; (b) the mental status of the shooter—including the degree to which mental state can be assessed and violence predicted and prevented; and (c) the social context—including the environment of the shooting and the broader cultural values, norms and social contracts that guide our behavior in everyday life, and in particular the use of arms.

Guns

According to the AMA, "uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths."[8]

This position mirrors one of the core principles of public health practice. The removal of potential sources of harm from our shared environment is a primary tool of public health. In the healthiest communities, the choices that individuals make in their daily routines have been shaped toward health, often as the result of policy. For example, due to the clear evidence of the benefit of seat belts, we do not have the legal choice to drive without them. The choice to light up a cigarette has been severely restricted because of the harm smoking is known to cause.

The evidence is clear that owning a gun makes us less safe. Households with a gun are more likely to experience gun-related injury or death than gun-free households, most often by household members on one another or themselves.[9] Reducing the presence of guns in our shared environment fits logically into the public health mandate. The choice to use a gun when spurred by a violent impulse is one that—due to its irreversible consequences—we would live better and longer without.

We're fortunate in Marin that our district attorney has conducted several successful gun buy-back programs, which effectively remove several hundred firearms from our community every year. While such efforts to reduce the approximately 3 million firearms in American households are vital, they are not enough.

Currently the AMA supports a waiting period before someone can purchase any form of firearm, background checks for all handgun purchasers, stricter enforcement of present federal and state gun safety legislation, and mandated additional penalties for crimes committed with a firearm, including illegal possession.

Mental health

Some responses to recent mass shootings focus on the mental health of the shooter. Some gun lobbyists suggest the primary solution is making gun ownership illegal for all those with mental illness. The U.S. Department of Health and Human Services reports that one in four adults—approximately 60 million Americans—experience a mental health disorder in any given year. One in 25 Americans lives with a serious mental illness such as schizophrenia, major depression or bipolar disorder.[10] Clearly, most of these people are not violent, and most violent crimes are committed by those with no psychiatric history.

Marin County averaged 14 gun-related deaths annually from 2009 to 2014. Of these, 84% were suicides.[11] Controlling gun violence locally clearly relies on mental health approaches to suicide prevention, as well as decreased access to guns.

So, while mental illness is clearly not the sole cause of gun violence or mass shootings, this is an opportunity to shine light on the reality that many people living with mental illness are not identified or provided with the treatment they need. We need consistent support for programs for early detection of mental illness or its precursors in schools, and for the Affordable Care Act's prioritizing mental health services in primary care settings.

Social context

While Americans represent less than 5% of the world's population, the U.S. is home to between 35% and 50% of all civilian-owned guns—with an estimated 89 guns for every 100 civilians.[12] It should come as no surprise then that the U.S. has more gun violence, gun crimes and gun deaths than any other country. The media's routine reporting of this violence normalizes it, for some, as a way to resolve disputes. Health care providers and public health agencies share a role to educate the community on the dangers of guns in the home. Some states have passed laws that limit physicians' ability to screen families for guns in the home or to counsel parents on the safe handling and storage of guns. This highlights the need for clinicians to remain aware of political and social factors that determine medical practice, and speak out against policies that threaten evidence-based care.

The approach to gun violence is an area where our medical societies and the county public health agency are clearly aligned. We recognize shared responsibility in creating an environment in which people can live healthy lives. Medical societies and public health advocates must support strengthening gun violence research and evidence-based control laws. We can use our voices to challenge the social norm of accepting the ubiquity of arms.

Physicians are too often firsthand

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witnesses to the damage of gun violence—to the victims, their families and our communities. Putting political differences aside, as local stewards of public health we should respond to these daily tragedies with honest outrage over the availability and routine use of firearms against ourselves and one another. A public health approach to gun violence, fueled by physicians' firsthand experiences, can move public dialogue toward policies and practices that will make our communities safer. ◆

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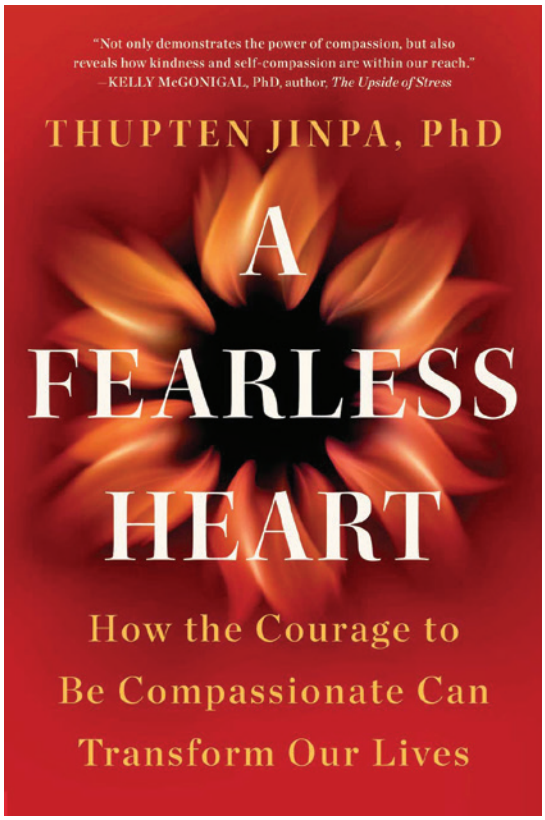
'A Fearless Heart: How the Courage to Be Compassionate Can Transform Our Lives'

Naveen Kumar, MD


"Not only demonstrates the power of compassion, but also reveals how kindness and self-compassion are within our reach."
—KELLY McGONIGAL, PhD, author, The Upside of Stress
THUPTEN JINPA, PhD
A FEARLESS HEART
How the Courage to Be Compassionate Can Transform Our Lives

As I began reading this book, I had some initial doubts about its utility. "Why do I need to read a book about compassion? As a physician, I have dedicated my life toward healing others. Isn't that compassion enough?" Interestingly, as I read further it became clear that physicians often forget a key element of compassion: compassion toward ourselves. As author Thupten Jinpa, PhD, writes, "Neglecting our own needs can lead to emotional burnout over time, leaving us depleted and exhausted. It's a common problem for those on the frontline of healthcare." In fact, physician burnout is one of the reasons that Kaiser San Rafael Medical Center, under the leadership of my colleague, Dr. Nirupam Singh, offers a Stanford-based eight-week Compassion Cultivation Training (CCT) course for interested physicians.

Dr. Kumar is a diagnostic, vascular and interventional radiologist at Kaiser San Rafael.

The goal of the book and the course is to bring us back to a fundamental aspect of human nature, which is to be compassionate. The problem is that many of us put compassion aside as we struggle to make it through our busy days and lives. However, we pay an emotional price for this. One vignette describes a burned-out young physician who, after taking the course, says, "It feels like what I do has meaning again and I feel more balanced. I intend to keep practicing medicine and compassion."

Even for those unable to enroll in the program, the book gives numerous practical techniques for "building our compassion muscle." Like any skill, compassion has to be actively nurtured through training and exercises. These include things like setting intentions (i.e., identifying positive steps you intend to take), cultivating awareness and mindfulness, and focusing the mind through meditation. The exercises are secular, but they are fundamentally based on Buddhist traditions and are described in detail in the book. The author is a former Tibetan monk, and he draws on his past experience and training throughout the book. His own story, as a Tibetan refugee growing up in India, is fascinating. Despite a difficult childhood and losing his mother at an early age, he perseveres and becomes the interpreter for the Dalai Lama.

Luckily the book is a quick read, and as I went through it I found myself identifying more compassion opportunities on a nearly daily basis. One of the radiology technologists I work with does an amazing job of caring for women as she takes mammograms for the early detection of

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Your support is needed to ensure that the Marin Medical Society (MMS) continues to be an effective advocate on your behalf on local and state health care issues.

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MMPAC is a voluntary political organizaton that contributes to candidates for local office. Political law and MMPAC policy determine how your contribution to MMPAC is allocated. A decision not to contribute to MMPAC will not affect your membership status with the MMS. MMPAC is sponsored by the Marin Medical Society. Contributions are not deductible for income tax purposes.

breast cancer. One day a patient told her, "Your job sucks." When I heard this, my initial reaction was anger at a patient who would disparage my staff this way. I caught myself though and was quickly able to turn that anger into compassion for a patient who was undoubtedly scared, nervous and likely experiencing difficulties in her life. The opportunities are there, in both our personal and professional lives, as long as we have the awareness to look for them.

I have actually started sharing the teachings in the book with my children. School is a place where compassion can often get lost. My 10-year-old son has a strong allergic reaction to gluten. When a schoolmate recently offered him a cookie, he said, "No, thank you. I have an allergy to gluten." The child then threw the cookie at him saying, "Your life must suck. You should commit suicide." When I heard about this I was again angry, but I learned about compassion from my son who was concerned for what might be going on in the other child's home. He worried that perhaps the child was abused . . . why else would he say such hurtful things? In fact, Dr. Jinpa describes how compassion and mindfulness can be incorporated into schools with robust effects on children's behavior.

Ultimately, the goal of any training is to bring about change. For compassion training, the change is how we behave in the world. This may sound like a lofty, almost unreachable goal, but any big change is made up of multiple small ones that build up gradually over time. Since reading the book, I have seen some changes in my own life, but more importantly I now look for new opportunities for compassion.

Even more exciting is the power that could arise from having multiple people in an organization consciously practicing compassion. As the author writes, "The very ethos of our healthcare system can and must stem from compassion."

In sum, this excellent book is a must-read for health care professionals. ◆

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October 2016

awards

PETER N. BRETAN, JR., M.D., FACS

WINS 2016 ADARSH S. MAHAL, M.D., ACCESS TO HEALTH CARE AND DISPARITIES AWARD

The California Medical Association (CMA) Foundation is pleased to honor Peter N. Bretan, Jr., M.D., FACS, with the 2016 Adarsh S. Mahal, M.D., Access to Health Care and Disparities Award. This award was established by 2007 CMA President Anmol S. Mahal, M.D., and his wife, Surjit K. Mahal, M.D., to honor an individual or organization that has made a significant contribution toward improving access to health care or reducing disparities in health care in California.

Dr. Bretan has demonstrated a longstanding dedication to improving individual and community health through effective leadership at a variety of levels including local, state, federal and international engagement. As the founder and lead transplant surgeon for Life Plant International, a charitable organization, Dr. Bretan promotes disaster preparedness, organ donation and early disease screening in the U.S. and abroad. He organizes and participates in life-saving medical missions that include performing and teaching about kidney transplants and laparoscopic kidney removals.

Dr. Bretan is a practicing renal transplant surgeon and urologist, with special training in laparoscopic surgery. Not only does he care for patients in Marin and Sonoma counties, he has also improved access to care by providing much-needed renal transplant and urological services to rural areas via robotic telemedicine at nine northern California hospitals.

Dr. Bretan has published over 200 scientific articles covering both clinical and original research subjects, which have been the basis of multiple academic awards. He speaks internationally as a recognized expert in kidney transplantation, as well as prostate and bladder diseases, and serves as a reviewer for six clinical and scientific journals in this capacity.

Dr. Bretan received his medical degree and completed his residency at the University of California, San Francisco. He is active in the Philippine Medical Society of Northern California, participating in its medical missions to the Philippines. He is also currently serving his fifth term as president of the Marin Medical Society and has been a delegate for CMA and the American Medical Association House of Delegates.

CMA Delegates Discuss Major Issues

2016 delegates in session. ***Inset:*** *Delegates from District X represent counties of Humboldt, Del Norte, Marin, Mendocino, Lake, Napa, Solano and Sonoma.*

More than 500 California physicians convened October 15–16 at the Sacramento Convention Center for the 145th Annual Session of CMA's House of Delegates (HOD). The meeting marked the end of the first year of CMA's new governance reforms and the first time the delegates had reconvened since approving the reforms at last year's HOD session.

Under the new system of governance, proposed policies are considered on a quarterly basis, with online testimony throughout the year. The HOD still meets annually, but the delegates now establish broad policy on current major issues affecting members, the association and the practice of medicine.

Major issues discussed this year were:

MACRA: As the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is implemented over the next several years, the CMA will be working hard to ensure it is workable for practicing physicians and improves patient care. The HOD discussed various recommendations to guide CMA's policy on this issue.

Maintenance of Certification: CMA supports the highest standards for licensure that are based on education, training, experience and ethical criteria. In a sometimes heated debate, delegates discussed various models and proposals regarding maintenance and recertification of specialty board certification, including alternative approaches.

This article is adapted from a CMA news release.

Opioids: The issue of opioid-related misuse, abuse and overdose continues to be a major policy issue at the federal, state and regional levels. The delegates discussed various strategies and policies to promote prescribing controlled substances safely and effectively to relieve pain, while simultaneously reducing the risk of prescription medication misuse, addiction and overdose.

Physician Burnout: Recognizing that it is the responsibility of the medical community to identify risk factors for and appropriately respond to signs of physician burnout, the CMA House of Delegates explored strategies to preserve the physical and mental well-being of physicians.

ACA Changes: Beginning in 2017, states can request a five-year renewable exemption on key coverage provisions within the Affordable Care Act, including those related to benefits and subsidies, the exchanges, and the individual and employer mandates. The HOD discussed various recommendations related to a possible Section 1332 waiver for California.

Five-Year Public Health Plan: For many decades, CMA has taken an active role in championing notable and successful public health policy campaigns that promote healthy practices and behaviors. Continuing its commitment to public health, the HOD discussed strategies to prevent and treat chronic disease and support healthy, safe communities, focusing on the following areas: adult and childhood obesity, tobacco use, pain, behavior health disorders, violence and infectious disease.

Before debating the issues, the delegates heard from experts in each major issue area, and for the first time continuing medical education (CME) credit was offered for these educational sessions. Final reports detailing the actions taken by the delegates are posted at www.cmanet.org/hod.

In addition to these discussions, Ruth Haskins, MD, was installed as CMA's 149th president. The HOD also elected Theodore M. Mazer, MD, president-elect. ◆

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CALIFORNIA MEDICAL ASSOCIATION

CMA's **Center for Economic Services** (CES) offers resources and guidance to improve the success of your practice. Assistance ranges from coaching and education to direct intervention with payors or regulators. Access to CMA's practice management experts is a members-only benefit.

The information on these pages is excerpted from the CES web pages at **www.cmanet.org/resources/reimbursement-assistance/.**

REIMBURSEMENT ASSISTANCE

Having Payor Problems? Need Help?

Members contact CMA's reimbursement helpline, at **888-401-5911** or **economicservices@cmanet.org.**

CMA's Center for Economic Services (CES) is staffed by practice management experts with a combined experience of over 125 years in medical practice operations. Our goal is to empower physician practices by providing resources and guidance to improve the success of your practice. In the past three years, CES successfully recouped over $7 million from insurance companies on behalf of our physician members.

WHEN DO I CALL CMA?

CMA members can call on CMA's practice management experts for free one-on-one help with contracting, billing, and payment problems. If you answer "yes" to any of the following questions, it might be time to call for help.

- Are your claims not being paid in a timely manner?
- Are you not being paid according to your contract?
- Are your claims being denied after obtaining prior authorization or verifying eligibility?
- Are you receiving unreasonable requests for medical records or untimely requests for refunds?
- Are you having difficulty obtaining fee schedules and/or payment rules?
- Are your claims being denied for timely filing?
- Have you been presented with a managed care contract and you're not sure if the terms are consistent with California law?
- Have you done everything you can to resolve an issue with a payor, including appealing, and have been unsuccessful in getting the payor to resolve the issue?

PRACTICE MANAGEMENT TOOLS AND RESOURCES

Whether it's identifying and fighting unfair payment practices, improving the efficiency of your practice, or negotiating payor contracts, CMA has tools and resources to help.

TOOLKITS

- Ask the Expert: Billing Medi-Medi patients
- MACRA: What Should I Do Now to Prepare? A checklist for physician practices
- What Physicians Need to Know to Avoid Penalties Under the New Provider Directory Accuracy Law
- Meaningful Use Hardship Exception FAQs
- Surviving ICD-10: An FAQ for physician practices
- ICD-10 Transition Guide—What physicians need to know
- Updating Provider Demographic Information with Payors
- Medicare Incentive and Penalty Programs: What physicians need to know
- Cal MediConnect Physician FAQ: What you need to know about keeping your patients and billing for the dual eligible population
- A Physician's Guide to Implementation of SB 866: The new standardized prescription drug prior authorization form
- Surviving Covered California (several titles)
- Medi-Cal Survival Guide: Important Changes and What They Mean to Your Practice
- Medicare Transition Guide: What physicians need to know
- Medi-Cal Primary Care Physician Rate Increase FAQs
- CMA's Got You Covered: A physician's guide to Covered California, the state's health benefit exchange
- TRICARE Transition Guide: What physicians need to know
- Aetna Termination Resource Guide
- Taking Charge: A step by step guide to evaluate and prepare for negotiations with managed care payors
- Best Practices: A Guide for Improving the Efficiency and Quality of Your Practice
- CMA Balance Billing Advocacy Tool Kit
- Medicare Enrollment Guide for Individual Physicians

PUBLICATIONS

- ***CMA Practice Resources*** (CPR)

KNOW YOUR RIGHTS

- Know Your Rights: Timely Filing Limitations
- Know Your Rights: Timely Payment
- Know Your Rights: Timeframes to Appeal
- Know Your Rights: Quick Guide for Appeals
- Know Your Rights: Identify and Report Unfair Payment Practices
- Know Your Rights: Filing a formal complaint with the regulator

PAYOR CONTRACTING

- Contract Renegotiations: Making Your Business Case
- Blue Shield Contract Analysis
- Taking Charge: A step by step guide to evaluate and prepare for negotiations with managed care payors
- Contract Amendments: An Action Guide for Physicians
- CMA Analysis of Major Health Plan Contracts
- Anthem Blue Cross Prudent Buyer Contract Analysis
- Health Net Contract Analysis

BILLING/CODING

- New CMS 1500 Implementation Reference Guide
- CMA Medicare Consultation Code Billing Guide

SAMPLE LETTERS, CHECKLISTS & WORKSHEETS

- Financial Impact Worksheet
- Payor Solvency Checklist
- Sample Tracking Sheet: Health Plan Acknowledgement of Receipt of Claim
- Sample Termination Letter - Patient
- Sample Termination Letter - Material Modification to Contract
- Sample Letter - Request for Complete Fee Schedule and Detailed Payment Rules
- Sample Letter - Request for Copy of Signed and Executed Contract, Complete Fee Schedule and Detailed Payment Rules
- A/R Phone Call Follow up Log Template

OTHER RESOURCES

- Special Investigations Unit Audit Guide
- CMA Timely Access Guide
- Medicare Electronic Prescribing (eRx) Overview
- Patient Handout: FAQ About Accountable Care Organizations (ACOs)
- Heritage California Accountable Care Organization (ACO) Physician Frequently Asked Questions
- Medicare Audit Guide for Physicians

CMA ON-CALL

This **24-HOUR ONLINE HEALTH LAW LIBRARY** contains nearly 5,000 pages of CMA On-Call documents and valuable information for physicians and their staff. Access to the library is free to members. Nonmembers can purchase documents for $2 per page.

1-800-786-4262 • www.cmanet.org/cma-on-call

MMS Awards Dinner 2016

The evening of Wednesday, September 28, was balmy, but inside Jason's Restaurant in Greenbrae, autumn was in the air. Or, to be a little more precise, it was on the tables, adorned with colorful fall decor to greet the roughly 70 guests at the Marin Medical Society's 2016 Awards Dinner.

MMS President Dr. Peter Bretan emceed the event, the highlight of which was, of course, the award presentations.

Dr. Grant Colfax introduced **Dr. David Witt,** who was honored with the award for **Outstanding Contribution to Community Health,** in appreciation of his leadership of the Marin Immunization Coalition, which contributed to local support for and the eventual success of SB 277.

Dr. Julia Haimowitz made the introduction of **Dr. Jeffrey Schneider,** to whom the **Outstanding Contribution to Marin County Medicine** award was presented, to honor and recognize his many dermatology-related contributions, including being a regional expert in melanoma for his peers and for his research project on the impact of skin cancer screening on melanoma survival rates.

Dr. Naveen Kumar called **Dr. Lori Selleck** to the podium and presented her with the award for **Outstanding Contribution to MMS** in recognition of her contributions to the goals and ideals of organized medicine while demonstrating an exemplary level of leadership and continually advancing physician participation in MMS and CMA.

Dr. Irina deFischer introduced **Dr. Gail Altschuler** and, in appreciation of her article "Healthy Weight, Healthy Pregnancy" from the spring-summer 2015 issue of *Marin Medicine,* presented her with the **Article of the Year** award.

To conclude the evening, Dr. Matt Willis presented the **Recognition of Achievement** award to **RxSafe Marin** for addressing the problem of prescription drug misuse and abuse and for adopting guidelines for the use of opioids in the treatment of chronic non-cancer pain. Accepting the honor was the entire project team:

Data Action Team co-leads: Karina Arambula and Timi Leslie

Community-Based Prevention co-leads: Kristen Law, Greg Knell and Sue Ragen

Intervention, Treatment and Recovery co-leads: Dena Martin and D.J. Pierce

Prescribers and Pharmacists co-leads: Teri Rockas and Matt Willis, MD

Law Enforcement co-leads: Mark Dale and Shae Cross

Outstanding Contribution to Community Health: Dr. David Witt *(right) and presenter Dr. Grant Colfax.*

Outstanding Contribution to Marin County Medicine: Dr. Jeffrey Schneider *and presenter Dr. Julia Haimowitz.*

Outstanding Contribution to MMS: Dr. Lori Selleck *(right) and presenter Dr. Naveen Kumar.*

Article of the Year: Dr. Gail Altschuler *(right) and presenter Dr. Irina deFischer.*

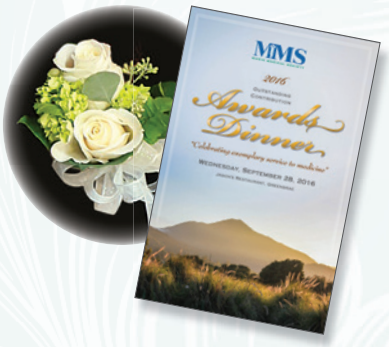
Recognition of Achievement: RxSafe Marin ***Back row:*** *Dena Martin, Mark Dale, Dr. Matt Willis, Timi Leslie and Greg Knell.* ***Front row:*** *Kathy Koblick, Peter Behel, Karina Arambula, Kristen Law, Maureen DeNieva-Marsh.*

Drs. Peter Bretan, Scott Sinnott and Jeffrey Dietz.

MMS president-elect Dr. Michael Kwok and his wife, Dr. Grace Kwok.

Dr. Shilpa Marwaha and Dr. David Witt.

Andrew Brisky (MIEC), Dr. Ann Vercoutere (MIEC Board of Governors), and Bill Green (MIEC).



David Pattison, Dr. Jeanne-Marie Sinnott, Dr. Irina deFischer and her husband, Dr. Scott Sinnott.

Dr. Bretan delivers closing remarks.

All photos by Will Bucquoy

SONOMA COUNTY MEDICAL ASSOCIATION

Oct. 26, 2016

Dear SCMA, MMS and MLCMS Boards:

This month I am celebrating 25 years with SCMA . . . time certainly does fly when you are doing what you love. So many years, projects, dinners and events, publications, challenges, changes, achievements and meetings—so many meetings! I'm grateful to have had the opportunity to work with these amazing organizations for many years, and for the privilege of collaborating with many wonderful, dedicated physicians. I believe I've had the best job ever, and thought I would be the executive director who didn't know when to leave. I imagined the boards would have to draw straws to decide who was going to tell me it was time . . . .

But here I am telling you it's time. I'm leaving for the best of reasons though—I've accepted a position as practice manager for a new solo practice in Santa Rosa. My son, Cuyler Goodwin, graduated from the UCSF psychiatry residency program this summer and opened Sequoia Mind Health with a promising future. I am profoundly honored to have this opportunity to help Cuyler, and humbled to have been asked. My last day with SCMA will be Dec. 31, 2016.

While I am looking forward to a new career, I am sad to be leaving. It has been an extraordinary privilege to work for you. I've been honored by your faith in my representing both your interests and those of your patients. Thank you for the opportunity, and for trusting me with that precious responsibility. I have learned much from each of you, and I greatly admire your dedication to your patients, to our communities, to collaboration and to the principles of organized medicine.

Your SCMA staff is without question the best. Every day they demonstrate what loyalty and dedication truly mean, and I could not have achieved half of what we've accomplished without their help. I will miss this extraordinary team.

I want to thank each of our past presidents, all of whom helped guide me for these past 16 years as your executive director. I'd like to especially thank Dr. Paul Marguglio, who was president in 2000 when SCMA was informed it was being shut down with a bankruptcy filing imminent. I will always be in debt to him and the board of directors for believing in me and giving me a deeply appreciated, once-in-a-lifetime opportunity to help rebuild and grow the organization. In 2007, SCMA began providing executive director, administrative and operational services for the Marin Medical Society, and in 2009 for the Mendocino-Lake County Medical Society.

Also, I would like to acknowledge those who served on the three boards of directors during my term—thank you for your support and commitment to your societies.

I close with best wishes for the continued success of your practices and our medical community.

Sincerely,

Cynthia Melody
SCMA Executive Director
1991–2016

With the resignation of our long-time executive director at the end of 2016, the boards of directors for the Sonoma, Marin, and Mendocino-Lake County medical societies have planned several meetings to look at current organizational structures and consider options for 2017 and beyond. Updates will follow in the monthly* News Briefs *newsletters.

▪ Regina Sullivan, SCMA President ▪ Peter Bretan, MMS President
▪ Karen Tait, MLCMS President

CMA's Unseen Legislative Battles: AB 533 vs. AB 72

Peter Bretan, MD, FACS

Jürgen Regel, Marianne Zocher-Regel, Wikimedia Commons

One of the great difficulties in maintaining membership for the Marin Medical Society (MMS) and the California Medical Association (CMA) is trying to be all things to all members. This can be extremely difficult since we have such a diverse membership and modes of practice. One of the toughest challenges we face is to show members the work we do all-but-invisibly on a daily basis.

Our Small and Solo Group Practice Forum (SSGPF) used to represent the dominant mode of practice, making up over 75% of our membership for more than 20 years. Economic forces and an ever-evolving medical practice landscape have changed that significantly, so that many solo practices have joined multi-specialty groups or larger practices. The SSGPF now accounts for only about a third of our membership. Unfortunately, it is the SSGPF that is disproportionately hurt by much recent legislation. It is the goal of the Marin Medical Society and the California Medical Association to battle and overcome some of these bills, which would not merely hurt solo/small practices but threaten their very survival.

Many of the CMA's struggles are invisible to the membership, and sometimes certain bills' passage appears to occur because of neglect by the CMA. Nothing could be further from the truth. Often, when a controversial bill passes, it is the lesser of two evils. This is what happened in the recent passage of **AB 72 over its more sinister twin, AB 533.** Both bills were introduced by Assemblyman Robert Bonta of Alameda, and both were labeled as "Surprise Billing" legislation. They were introduced because out-of-network billing prompted many patients to complain to the Legislature.

These bills are a byproduct of insurance companies' narrow and inadequate physician networks, which almost guarantee that out-of-network physicians are often dragged in to care for patients insured by these companies. These patients get procedures from anesthesiologists, surgeons, radiologists and other non-contracted, hospital-based doctors who are thus "out of network" when they are on call at an in-network hospital. The patient then gets slammed with a "surprise billing." Obviously this is the fault not of the provider, but of an inadequate insurer network. Unfortunately, insurers have been using this loophole to avoid paying providers adequately. Also unfortunately, AB 72 eliminates "surprise billing" by transferring this cost to the non-contracted, out-of-network providers. Many solo practitioners perceive this as a slippery slope, a ramp-up to unregulated capitated care as a consequence of insurers' narrow networks, which angers many struggling providers. The most damaging accusation is that CMA did not fight to prevent this. On the contrary, CMA did everything possible. Let me outline here just what it did.

Dr. Bretan, a urologist and transplant surgeon in Marin, Sonoma and Mendocino counties, is president of MMS, a member of the CMA and AMA delegations, and a former CMA trustee.

AB 533 was the first of these bills to be introduced. It would have required non-contracted physicians to sign a written consent form 72 hours before providing a service. It also called for reimbursement at 125% of the Medicare rate. CMA consistently opposed AB 533 and proposed a solution similar to legislation passed in New York using the interim payment metric of the 80th percentile of the Fair Health database. However, the Legislature didn't agree. Supporters of AB 533 included all major labor unions, health plans, consumer groups and the California Chamber of Commerce. CMA was able to defeat AB 533 by keeping it short of the 41 votes necessary for passage at the end of 2015. Unfortunately, the bill could still be brought up for reconsideration at any time after that.

AB 72 was offered as an alternative to 533. When it was being vetted by CMA, it received input from a broad representation of physicians from every mode of practice. CMA's various forums had spokespeople at each CMA Board of Trustees meeting. By ensuring stakeholder participation in the AB 72 development process, CMA was able to secure improvements in AB 72 that made it better than AB 533. CMA was able to get the Legislature's support for these changes in the bill by switching its position from "opposed" to "neutral." This was CMA's only option—to seek the support of allies in pushing for AB 72 over AB 533. Despite the ongoing effort to make AB 72 more palatable than AB 533, our SSGPF asked CMA to send a letter to the governor urging him to veto AB 72 just at the time that CMA was in the midst of actively working to amend—to improve—AB 72 so as to destroy AB 533. Obviously, sending such a letter would have killed CMA's credibility in the effort to make AB 72 as palatable as possible—and perhaps the credibility of future CMA efforts as well.

What some physicians fail to realize is that there is truly no support in the Legislature for holding patients responsible for services they never agreed to. CMA's stance has been that the insurers are responsible for these costs, since they are the direct result of the insurers' narrow networks, which are in turn the result of inadequate reimbursements to providers. Nevertheless, that is irrelevant to the negotiation process in the Legislature, especially since we needed the insurers' support for AB 72 over AB 533.

The CMA Board of Trustees directed the CMA Government Relations staff to negotiate the best deal possible for AB 72 as a replacement for the more damaging AB 533. **The CMA leadership understood that this was the right thing to do despite the protest from unengaged members of the SSGPF.**

In its final form, AB 72 has been sent to the governor for signing. It includes these provisions:

- Health plans and insurers must pay physicians the greater of the average contracted rate or 125% of the Medicare reimbursement for that service.
- A non-contracting physician must get written consent with an estimate of the patient's total out-of-pocket cost for the use of out-of-network benefits more than 24 hours ahead of the scheduled service.
- The continuity-of-care provision in existing law will remain in effect. Thus in certain instances a patient may still have a right to get covered services from a non-contracted physician.
- **Most importantly, the bill now allows state health insurance regulators to better determine whether plans' and insurers' networks are adequate, and to take action if they are not.**

The battles fought by MMS and CMA at the state Legislature and by AMA in Congress are an ongoing saga. We may not always get what we want, but we fight for what we need**. I hope we can all understand that CMA/MMS look at the whole practice of medicine and the effect on our patients.** I hope you stay involved and always question what insurers and government are going to do to your practice, but understand that the negotiating effort requires credibility, patience and attention to detail. Rest assured that we are doing everything in our power for your practices, and that your membership enables us to fight day in and day out. ◆

Email: bretanp@msn.com

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The California Medical Association and the Marin Medical Society

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- Continuously defending the **Medical Injury Compensation Reform Act** (MICRA)
- Advocating for specialty scope of practice that **protects patients**
- **Leading public health efforts**, including decreasing youth smoking and passing a landmark immunization law

Other benefits of membership include professional, personal and practice resources, which commonly **offset the price of dues**. Learn more at www.cmanet.org/groupdiscounts.

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MMS
MARIN MEDICAL SOCIETY

A Component of the
CMA
California Medical Association

1 SELECT YOUR MEMBERSHIP PLAN AND PRICING:

CMA and Marin Medical Society Membership (required)*: ☐ **$96.00 per month**

*No more than $5.50 of CMA's monthly dues is directed to CALPAC, CMA's political action committee, to support candidates for public office who share CMA's philosophy. Members who object to this may check the box below to have these funds redirected to CMA's Independent Expenditure Committee, a fund for independent expenditures that does not directly contribute to candidates running for public office. ☐ Please deposit my portion of dues into CMA's Independent Expenditure Committee.

CMA and Marin Medical Society Membership, with CALPAC Membership (recommended): ☐ **$108.50 per month**

CALPAC is a voluntary political organization, operated by physicians, for physicians, that contributes to candidates for state and federal office who share CMA's philosophy.

Terms and Conditions for Monthly Payment Plan

By checking the box below you authorize CMA to make automatic recurring monthly charges on your credit card in accordance with these terms and conditions. Payment for your membership dues will be automatically charged to your credit card by the 5th business day of each month. If the credit card is declined for any reason, CMA will attempt to contact you to make other arrangements. Refunds will not be issued for processed payments.

This agreement will remain in effect and renews automatically each month until canceled by either party. Cancel anytime with no penalty. If you wish to cancel this agreement, have questions, or wish to update your credit card information, call CMA at (800) 786-4262.

2 ☐ I agree to these terms and conditions Signature: _____ Date: _____

3 General Information:

Name: _____ County: _____

Date of Birth: _____ CA Medical License No.: _____ Hours Worked Per Week: _____

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City: _____ State: _____ Zip Code: _____

Office Phone: _____ Home Phone: _____

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5 New Applicants Only:

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Specialty: _____ Gender: ☐ Male ☐ Female

Medical School: _____ MS Graduation Date: _____

Residency Program: _____ RP Graduation Date: _____

Name of practice, medical group or IPA affiliation(s): _____

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***Deductibility:** Association dues are not deductible as a charitable contribution for federal income tax purposes, but may be partially deductible as a business expense. A portion of your dues are not deductible because of lobbying activities CMA undertakes on behalf of its members. As a result, 34% of CMA dues cannot be deducted as a business expense for federal income tax purposes.

***CALPAC and CMA IEC:** CALPAC is a voluntary political organization that contributes to candidates for state and federal office who share our philosophy and vision of the future of medicine. Political law and CALPAC policy determines how your contribution to CALPAC is allocated. CMA and this component society will not favor or disadvantage anyone based on the amounts of, or failure to make, PAC contributions, nor will it affect your membership status with this society or CMA.

California Medical Association Independent Expenditure Committee (CMA IEC) is a fund established for communication expressly advocating the election or defeat of a clearly identified candidate that is not made in cooperation, consultation, or concert with, or at the request or suggestion of, a candidate, a candidate's authorized committee, or their agents, or a political party or its agents. The CMA IEC does not make direct financial contributions to candidates for public office.

Contributions to these groups are voluntary and not limited to the suggested amounts. Contributions are not deductible for state or federal income tax purposes. CALPAC and CMA IEC are sponsored by the California Medical Association.

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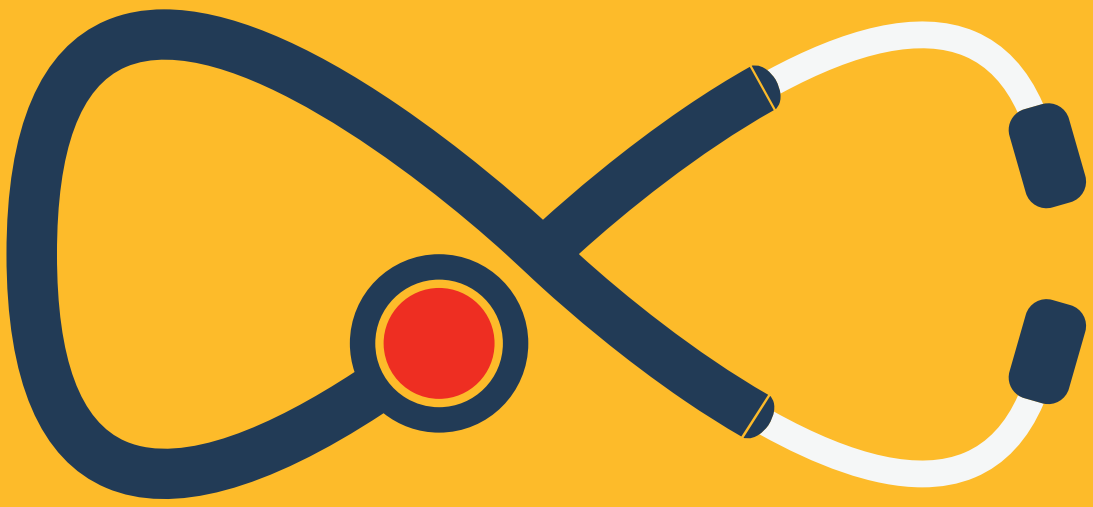

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